EAST AFRICAN COMMUNITY REGIONAL HIV AND AIDS RESPONSE REPORT 2013

REALIZING THE REGIONAL GOALS IN HIV AND AIDS, TB AND STI PROGRAMMING

POPULAR VERSION | November 2014

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EAC Partner States' Progress towards UN Targets on HIV and AIDS

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3. Eliminate new HIV infections among children/halve AIDS-related maternal deaths					
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5. Halve TB deaths among PLHIV					
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9. Eliminate HIV-related restrictions on entry, stay and residence					
10. Eliminate parallel systems for stronger integration of health, AIDS and development efforts					

Source: Country Progress Report (2011-2013) on the United Nations General Assembly 2011 Political Declaration on HIV and AIDS

Note Color Code: GREEN: On Track; RED: Not on Track; PURPLE: Not Indicated; YELLOW: No Data; BLUE: Not Applicable

INTRODUCTION

The East African Community (EAC) is the regional intergovernmental organization of the Republics of Burundi, Kenya, Rwanda, United Republic of Tanzania and the Republic of Uganda, with its headquarters in Arusha, Tanzania.

The objective of the Community is to widen and deepen economic, political, social and cultural integration in order to improve the quality of life of the people of East Africa through increased competitiveness, value added production, trade and investment.

The EAC region has a population estimated by the International Monetary Fund (IMF) at 144 million in 2012 and which is projected to exceed the 155 million mark by 2015. Life expectancy in the region is 51 years in Burundi; 54 in Uganda, 58 in Kenya, 59 in Tanzania and 63 years in Rwanda. Gross Domestic Product per capita in 2012 was $976 (Kenya), $693 (Rwanda), $599 (Uganda), $589 (Tanzania) and $282 (Burundi), according to the IMF.

About this report

The East African Community Regional HIV and AIDS Response Report 2013 is a first-of-its-kind consolidated reference on the status, trends and response to the HIV and AIDS epidemic in the EAC region. It is envisaged as a tool to assess progress made in reaching national, regional, continental and global commitments on the HIV epidemic.

This report is designed to generate evidence which will form the basis for re-programming the EAC response to the HIV and AIDS epidemic in pursuit of an early achievement of zero new infections, zero AIDS deaths and zero stigma and discrimination, and, to provide information necessary to support the region's advocacy and resource mobilization efforts in this regard.

A participatory approach was used in compiling this report. As such, it relies heavily on the input of various technical experts and draws heavily

from literature in the Partner States, the EAC Secretariat, regional and international bodies as well as the internet. This report uses data that was available as at December 2012. The EAC Regional HIV and AIDS Response Report 2013 was subjected to a series of validation processes, including review workshops at national and regional levels and, finally a peer review exercise by independent peer reviewers from the five EAC Partner States.

Important Note: The EAC Regional HIV and AIDS Response Report 2013 - Popular Version is a summarized presentation of the facts and findings contained in the unabridged EAC Regional HIV and AIDS Response Report 2013. Readers are encouraged to seek the latter for detailed coverage of the issues discussed in this version. Additional information about this report may be obtained from the EAC Secretariat, Arusha, Tanzania. (Telephone: +255 27 216 2100/Email contact: mkatende@eachq.org)

KEY RECOMMENDATIONS

This report presents recommendations for implementation at two levels, namely, EAC and Partner State. A summary of these recommendations is presented below:

EAC

- Institutionalize the production of the EAC Regional HIV and AIDS Response Report every two years in harmony with other mandatory regional and global reporting
- Facilitate the process of harmonizing minimum standards for surveillance of HIV and AIDS issues and service delivery within the region
- Facilitate the harmonization of national HIV and AIDS strategic plan development and timeframes to enhance monitoring and evaluation, for better comparison across Partner States
- Strengthen the Monitoring and Evaluation (M&E) system at the EAC Secretariat in terms of structures and personnel to facilitate availability of high quality data for performance monitoring and reporting and linkage with the EAC Partner States
- Enhance the provision of combination prevention services among pri-

ority populations (including transport corridor workers) by establishing a minimum package of services along the EAC transport corridors for key populations
- Conduct social behavioral and survey studies on sub populations and dynamics in order to guide prioritization of programming and policy interventions
- Develop a regional strategy for strengthening community systems to facilitate implementation of HIV and other health programs
- Formulate a regional policy on local pharmaceutical manufacturing and pooled procurement of HIV commodities including ARVs in order to benefit from economies of scale
- Work with Partner States to formulate a strategy for sustainable financing of HIV and health services based on the test and treat approach
- Advocate and harmonize regional laws and policies that enhance access of HIV services without discrimination of marginalized populations

Partner States

1. Enhance the scale-up of high impact combination prevention interventions such as safe male circumcision, ART, PMTCT, condom promotion, treatment as prevention, targeting sub populations contributing significantly to new infections in the region
    a. Strengthen mechanisms of ensuring universal access to services for pregnant women (ANC, eMTCT) and enhance the scale-up of option B+ as a strategy for expanding efficacious treatment throughout the EAC Partner States
    b. Harmonize and roll out the most up to date WHO guidelines as a way of scaling up HIV treatment that is a main component of the regional response for addressing the epidemic
    c. Strengthen the supply chain system for drugs and other supplies supporting ART services

2. Strengthen linkages/integration across the continuum of response and services to promote uptake of combination prevention interventions
    a. Scale up integration of interventions against HIV stigma and dis-

crimination in the comprehensive response to HIV and AIDS at family, community and institutional levels while also empowering PLHIV to live positively with the condition

b. Strengthen the integration of eMTCT into maternal, newborn and child health services
c. Increase screening for TB among HIV patients, provide PLHIV without active TB with isoniazid preventive therapy and commence ART for all HIV/TB co-infected patients regardless of their CD4 count
d. Create increased awareness on TB especially among people involved in cross-border movements
e. Strengthen diagnostics of TB among PLHIV and children through provision of sensitive diagnostic tools in health facilities such as GeneXpert

3. Strengthen information management systems and research to inform policy and programming
   a. Continuously devise, revise and update indicators and tools for data collection especially qualitative indicators
   b. Update the mode of transmission studies
   c. Conduct behavioral and social dynamic studies to inform policy and programming

4. Review laws and policies that negatively impact on the national response to HIV e.g. those that criminalize commercial sex work and HIV transmission

5. Increase financing for HIV and AIDS and related health services in the Partner States
   a. Employ strategies and interventions that efficiently and effectively utilize and strengthen existing health structures and systems (e.g. improve staffing, lab, supply chain management, M&E systems) for enhancing delivery of integrated services in the region
   b. Increase local finance allocations through AIDS trust funds and public-private partnerships
   c. Revitalize mainstreaming of HIV as a mandatory reporting and accounting requirement for approval of sectoral and local government plans

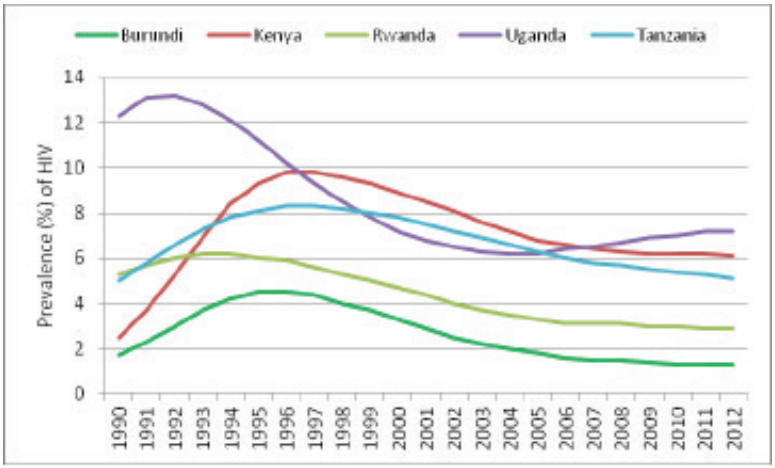
6. Promote strategies that increase access to HIV and other health services while empowering priority populations (vulnerable and key populations) socially and economically
   a. Address social and structural factors that predispose some sub populations to HIV infection based on gender
   b. Target and engage young people in the implementation of HIV services (young positives, OVC, girls etc) in and out of school
   c. Accelerate provision of combination prevention interventions among priority populations

HIV AND AIDS SITUATION IN EAST AFRICA

HIV prevalence in East Africa

The estimated prevalence of HIV among adults 15-49 years of age in 2012 was 1.3% in Burundi, 6.1% in Kenya, 2.9% in Rwanda, 7.2% in Uganda and 5.1% in Tanzania, according to UNAIDS. From 1990 to 2012, the trend of HIV prevalence steadily declined in all countries but not Uganda, where the decline stagnates and slightly rises between 2005 and 2014 (See graph).

Trend in HIV Prevalence in EAC Partner States, 1990-20



Source: UNAIDS Report on the Global AIDS Epidemic - 2013

UNAIDS estimated that in 2012 there were five million (4.6 - 5.3 million) people living with HIV in the region. Kenya, Uganda and Tanzania each contributed a third of the people living with HIV (PLHIV) in the region. (See Table)

Adults and Children Living with HIV, 2001 and 2012 in EAC Partner States

Partner State	Adults		Children		ALL	
	2001	2012	2001	2012	2001	2012
Burundi	100,000	72,000	30,000	17,000	130,000	89,000
Kenya	1,400,000	1,400,000	200,000	200,000	1,600,000	1,600,000
Rwanda	200,000	180,000	40,000	30,000	240,000	210,000
Uganda	830,000	1,400,000	170,000	100,000	1,000,000	1,500,000
Tanzania	1,300,000	1,200,000	200,000	300,000	1,500,000	1,500,000
TOTAL	3,830,000	4,252,000	640,000	647,000	4,470,000	4,899,000

Source: UNAIDS (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

New HIV infections in East Africa

Between 2001 and 2012 the number of people newly infected with HIV reduced from 390,000 to 330,000, representing a decrease of 14%. The number of new infections among adults and children reduced in Kenya, Rwanda and Tanzania. However, an increase in new infections among adults was observed in Burundi (65%) and Uganda (74%) as is shown in the table.

Number of New Infections among Children and Adults

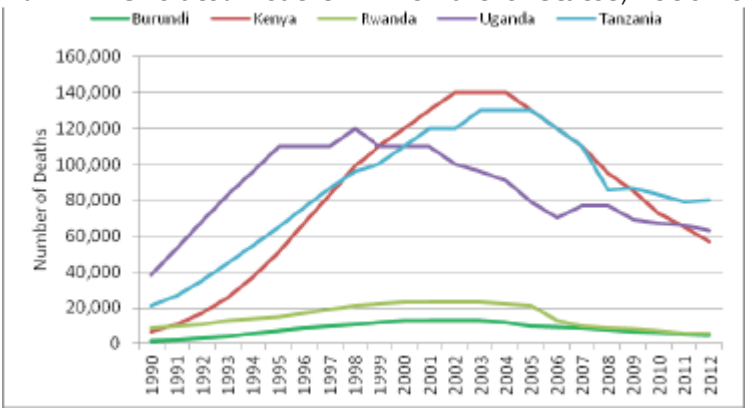
Partner State	**Adults**		**Children**		**ALL**	
	2001	**2012**	**2001**	**2012**	**2001**	**2012**
Burundi	2,000	3,300	3,600	1,300	5,600	4,600
Kenya	97,000	85,000	43,000	13,000	140,000	98,000
Rwanda	11,000	6,900	6,000	900	17,000	7,800
Uganda	69,000	120,000	25,000	20,000	94,000	140,000
Tanzania	91,000	69,000	39,000	14,000	130,000	83,000
TOTAL	**270,000**	**284,200**	**116,600**	**49,200**	**386,600**	**333,400**

Source: UNAIDS (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

AIDS Deaths in East Africa

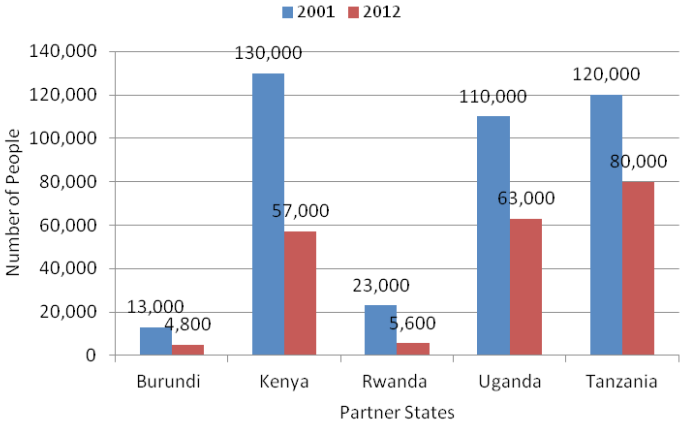
Between 2001 and 2012, a total of 3.6 million people were estimated to have died from AIDS with the majority being in Tanzania (35%), Kenya (33%) and Uganda (24%). The remaining eight percent were in Burundi and Rwanda (See graphs). There has been a significant decline in the number of AIDS-related deaths since 2005, attributed to the massive scale-up of ART availability, access and uptake.

Trend in AIDS-related Deaths in EAC Partner States, 1990-2012



Source: UNAIDS Report on the Global AIDS Epidemic - 2013

Deaths Related to AIDS in EAC Partner States, 2001 and 2012



Source: UNAIDS (2013). Global Report: UNAIDS report on the global AIDS epidemic 2013.

REGIONAL RESPONSE TO THE HIV EPIDEMIC

A multi-sectoral approach has been adopted by the EAC Partner States in the response to the HIV and AIDS epidemic. Each Partner State has:

(a) a National AIDS Council put in place by an Act of Parliament and is either in the Office of the President, Prime Minister or Ministry of Health;
(b) developed a time-bound national strategic plan with clear goals and priority interventions that guide the response at national and decentralized levels; and
(c) a coordination framework that covers the key public sector ministries and civil society and addresses coordination from national to sub-national and community levels.

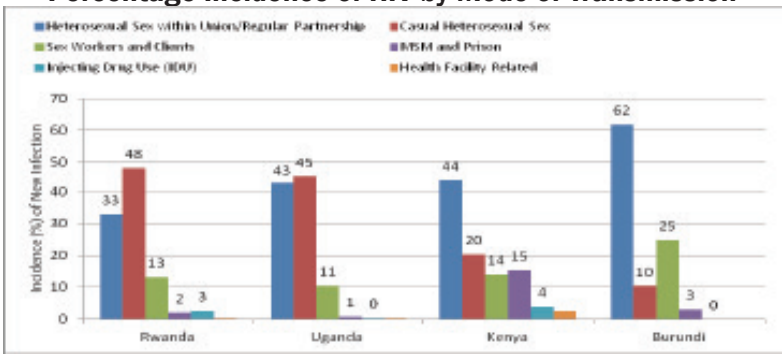
A national response cannot be effectively managed without a monitoring and evaluation system. Each Partner State and EAC has put in place an M&E framework to track performance in the implementation of their respective strategic plans.

MODES OF TRANSMISSION, MOST AT RISK POPULATIONS, KNOWLEDGE OF HIV

Most new infections in Kenya, Rwanda, Uganda and Burundi occur among heterosexual couples in a union/regular partnership, who are responsible a third or more of the new infections. Meanwhile casual sex partners account for half of the new infections in Rwanda and Uganda, and for one in every five new infections in Kenya and one in every 10 in Burundi.

Sex workers and their clients are responsible for about one in every 10 new infections except in Burundi where this mode of transmission is responsible for 25% of new infections. In Kenya, men having sex with men (MSM) and prison populations contribute about 15% of the new infections in that country. MSM contributes to 3% or less in the other countries. (See graph).

Percentage Incidence of HIV by Mode of Transmission



Source: KNAC (2009), CNLS (2009) and UAC (2009), Burundi (2012)

HIV Prevalence among Most at Risk Populations in the EAC Partner States

Most at risk populations (comprising sex workers, fisher folk, intravenous drug users, men having sex with men and prisoners) are the main source of new HIV infections. Female sex workers have the highest prevalence in all EAC Partners States as shown in the table below:

HIV Prevalence among Most at Risk Populations in EAC Partner States

Partner States	Source		Most at Risk Population				
			Sex Workers	MSM	IDU	Fisher folk	Prisoners
Burundi	BSS 2011		19	2		3	3
Kenya	MoH 2012		29	18	19	26	8
Rwanda	CNLS 2009		51				
Uganda	Crane 2010a		33	14	-	22	13b
Tanzania	TACAIDS 2008			12	25	8	-
Zanzibar	Unguja	ZAC, MOH 2011	19.3	2.6	11.3		
	Pemba		18.8	5.0	8.8		

Comprehensive Knowledge about AIDS

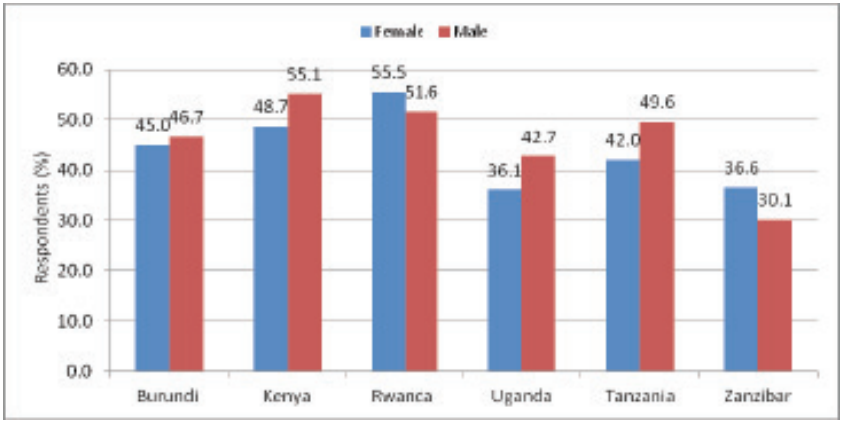
Almost all (99%) of women and men aged 15-49 have heard of AIDS in all EAC countries. Similarly, about nine out of ten adults in the region know

that limiting sexual intercourse to one uninfected partner or being faithful to one uninfected partner would help prevent HIV infection.

Four out of five adults know that condoms can be used to prevent HIV infection, while seven out of ten adults know that both using condoms and limiting sexual intercourse to one uninfected sexual partner is effective in reducing HIV transmission.

In the East African region, less than half the adults in Burundi, Uganda and Tanzania have comprehensive knowledge about AIDS. In Kenya and Rwanda where the knowledge is more widespread, less than two out of three adults have such knowledge. Overall, more men than women in each of the Partner States have comprehensive knowledge about AIDS, except in Rwanda where only 52% of men compared to 56% of women had such knowledge. (See graph)

Level of Comprehensive Knowledge about AIDS among adults aged 15-49 years



Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011) and THMIS (2011).

About 50% of those in prison had incorrect beliefs about HIV and AIDS with 20% of all those in jail believing HIV had a cure. It was also found that about 30% considered themselves at risk of acquiring HIV while in prison

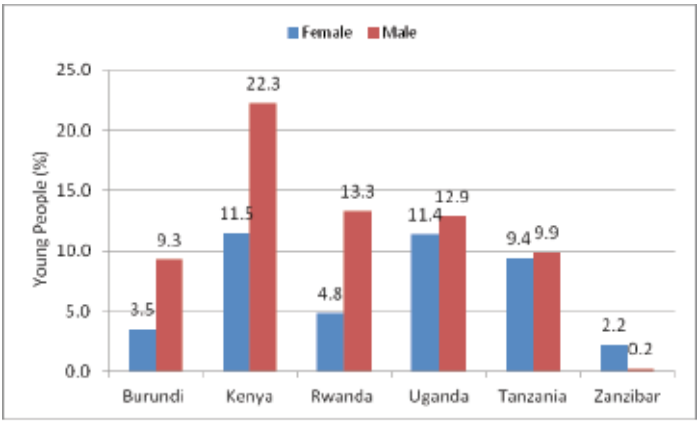
attributing the risk to sharing shaving instruments (62%) and unsafe sexual behavior (7%).

*Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about transmission--that the AIDS virus can be transmitted through mosquito bites and by supernatural means.

Early Sexual Debut among Youths

Although there is a strong advocacy and promotion of abstinence for young people, many young men and women in the EAC Partner States have already had sex by the age of 15. More than one in five boys aged 15-19 years in Kenya have had their sexual debut before age 15 compared to their counterparts in Burundi where only one in ten had done so. Burundi is also the country where the least number of young girls (4%) had initiated sex by age 15 compared to the other countries where more girls had already experienced sexual intercourse by age 15. (See graph)

Percentage of women and of men aged 15-19 who had first sexual intercourse by 15 years

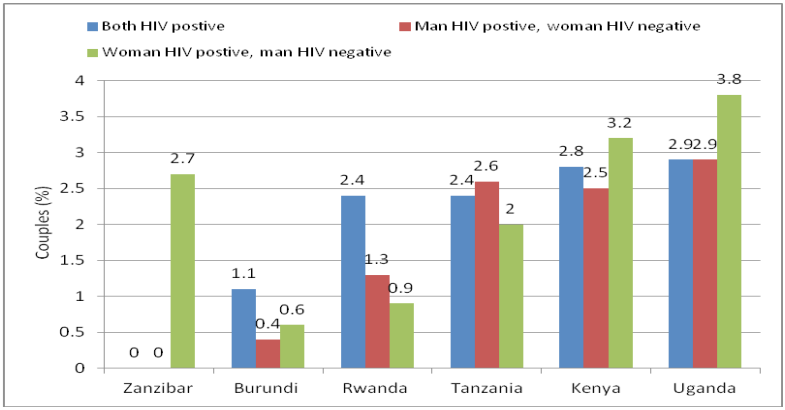


Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011) and THMIS (2011).

Sero-discordance in East Africa

Over 90% of the couples in the region are both negative and three percent of the couples have both partners HIV-positive. In Uganda, Tanzania and Kenya, nearly three percent of couples have the man HIV-positive and woman HIV-negative. There are more couples with woman HIV-positive and man HIV-negative in Uganda and Kenya than the opposite which is consistent with the prevalence rates in the general population. In Burundi and Rwanda, HIV sero-discordance is not very common, occurring only in 1% and 2% of the couples respectively.

Prevalence of Sero-discordance among Couples in EAC Partner Stat

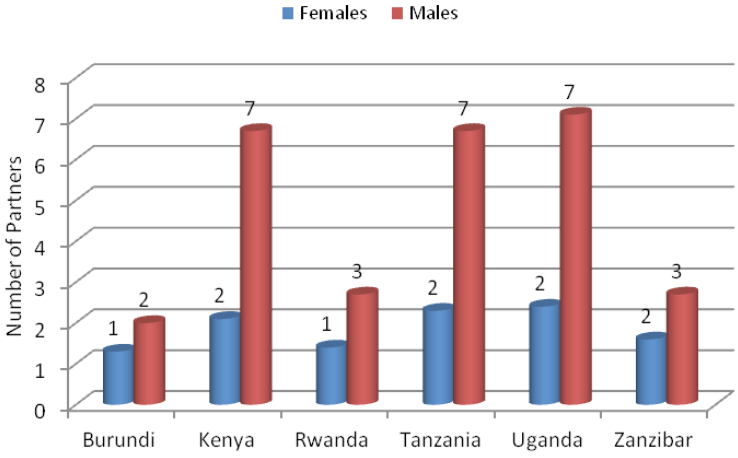


Source: BDHS (2010), KDHS(2010), RDHS (2010), UAIS (2011) and THMIS (2011).

Multiple Partnership and Condom Use

Men are more likely than women to have more lifetime sexual partners (average of seven versus two) particularly in Kenya, Tanzania and Uganda compared to Burundi and Rwanda (where women have one life time partner versus men with an average of two). (See graph)

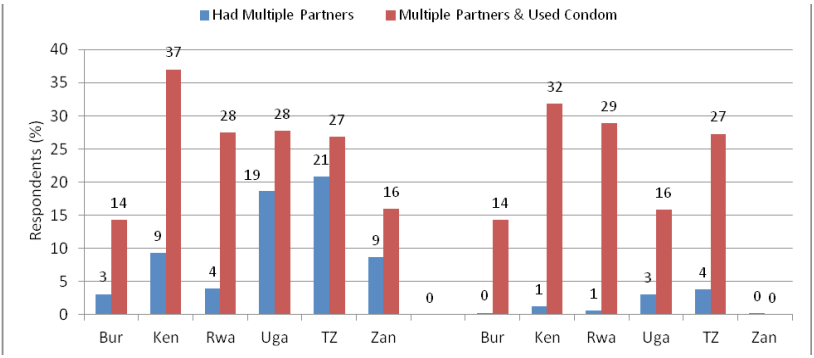
Number of Lifetime Sexual Partners among Adults Engaged in Multiple Sexual



Source: BDHS (2010), KDHS(2010), RDHS (2010), UAIS (2011) and THMIS (2011).

Among the men and women that had multiple partners in the last 12 months, about one in three of them in Kenya, Rwanda and Tanzania used a condom at the last intercourse. In Uganda, less than one in five men and women did so while in Burundi, only one in ten used a condom. In Zanzibar 16% of such men had used a condom. These findings imply that many adults are engaged in multiple unprotected sexual encounters.

Multiple Relationships and Condom Use among Men (left graph) and Women (right graph)



Source: BDHS (2010), KDHS(2008-09), RDHS (2010), UAIS (2011) and THMIS (2011).

Biomedical Interventions

Safe Male Circumcision

Studies have demonstrated that safe male circumcision (SMC) reduces HIV acquisition by about 50 - 60% among uninfected men. Accordingly, SMC has been scaled up at different rates in the Partner States. In Kenya, Tanzania and Burundi, over 85%, 72% and 33% of the men, respectively, have been circumcised while fewer men in Uganda (26%) and Rwanda (13%) have been circumcised.

In Kenya the prevalence of HIV among circumcised men was only 2.8% compared to 12.9% among those not circumcised. And the occurrence of sexually transmitted conditions was three times in non-circumcised men (6.1%) compared to those that were circumcised (1.5%) and this was comparable with data from Tanzania.

HIV Testing among Adults and Youth

In all the EAC Partner States more women tend to test for HIV than men. In Kenya, 57% of women compared to 40% men have ever tested and got their results; in Rwanda, the statistics were 76% and 69% respectively. On the other hand, in Uganda while 71% of women have ever tested and got

their results, only 52% of the men had done so. In Tanzania, 62% of women and 47% of men have ever undergone a HIV test and got their results.

ELIMINATING NEW INFECTIONS AMONG CHILDREN

All the Partner States are on track to meet the 2011 Political Declaration on eliminating new HIV infections among children and reducing AIDS-related maternal deaths by half. More women than men in the region know about both methods of preventing mother to child transmission of HIV, namely; avoidance of breastfeeding and use of special drugs. In Rwanda, the combined knowledge is at about 85% while it is only between 60% in Tanzania and 70% in Burundi.

Approaches for Eliminating Mother-to-Child Transmission of HIV

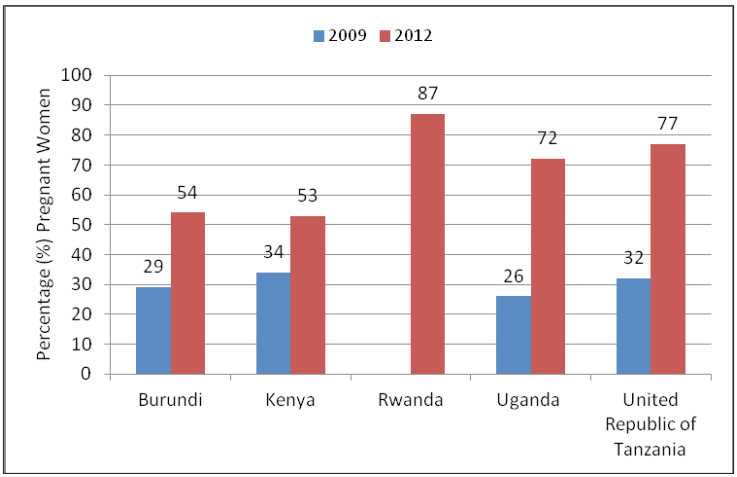
The comprehensive strategic approach for preventing HIV infection among infants and children includes four prongs. Namely;

Prong 1: New HIV infections among women 15-49: The number of new HIV infections among women aged 15–49 in the EAC Partner States declined by 4-10% between 2009 and 2012 which is low compared to the set target of 50% by 2015.

Prong 2: Prevention of unwanted pregnancies: Women living with HIV need regular access to and uptake of family planning services. About 70% of married women in East Africa have their family planning needs met.

Prong 3: Mother to Child transmission: All women should be counseled about HIV during antenatal care (ANC) and offered a test and those found HIV positive put on treatment. There is a big gap between pregnant women attending ANC who are provided with counseling and testing compared to those in need of HTC as indicated in the graph.

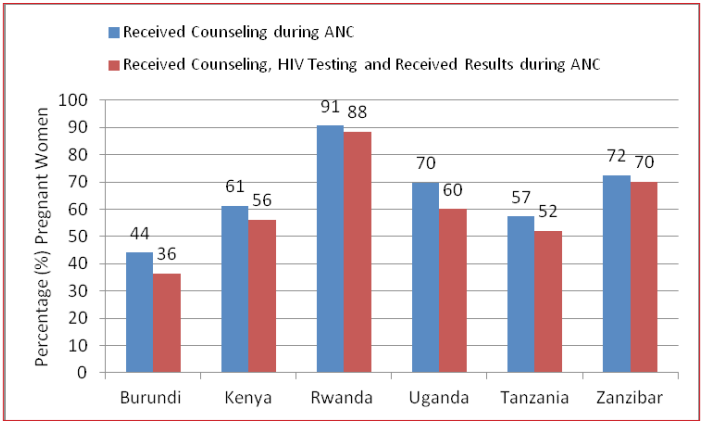
HIV Testing (%) among Pregnant Women Attending ANC



Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011), THMIS (2011)

Percentage of women receiving ARVs (excluding single dose nevirapine, sdnvp) to prevent MTCT: There has been considerable improvement in the proportion of pregnant women that received ARVs to prevent MTCT across the region as indicated in the table below.

Percentage of Women Receiving ARVs (excluding sdnvp) to Prevent MTCT



Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

Prong 4: Treatment, care and support to mothers and their children: Many HIV+ women are receiving ART as summarized in the table below.

Estimated Percentage of HIV+ Women Receiving ART for Their Own Health

Global Plan Country	2009	2012
Burundi	0	47
Kenya	42	58
Uganda	0	47
United Republic of Tanzania	17	56

Source: UNAIDS (2013): 2013 Progress Report on the Global Plan.

IMPACT OF EMTCT

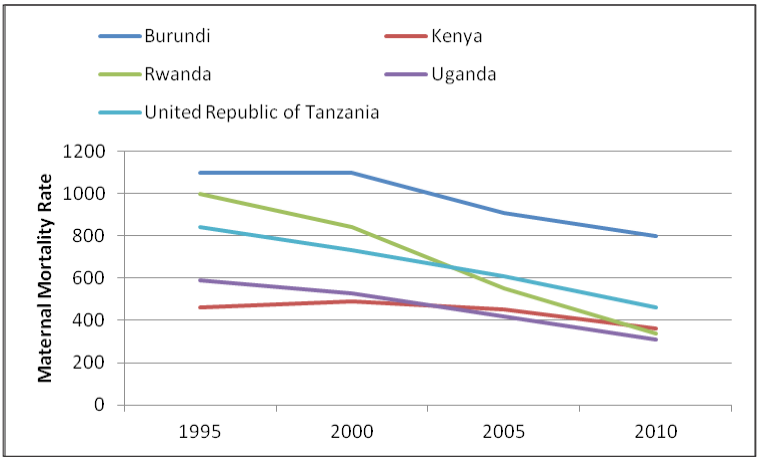
Reduction in Number of Children Newly Infected with HIV

There has been considerable progress within the region towards the elimination of MTCT. The total number of new infections in 2011 was only 44,150 representing a steady decline to 37% of what it was in 2000 which was at 118,500.

5.3.2 Maternal Mortality among HIV Infected Mothers

Maternal mortality rate has been rapidly declining in the EAC particularly in the years 2005 to 2010 following the introduction of ART compared to the rates between 1995 and 2000 when the HIV and AIDS epidemic was either at its peak and/or countries had inadequate care and treatment programs. To ensure that the trend in declining maternal mortality is sustained and accelerated, the region needs to ensure that all pregnant women attend all four ANC visits; deliver aided by skilled personnel and strengthen community systems to facilitate referrals and follow up.

Maternal Mortality Rate in Partner States, 1995-2010



Source: WHO (2012). Trends in Maternal Mortality: 1990 to 2012

PROVISION OF ANTIRETROVIRAL TREATMENT

Globally, the target is to reach 15 million people living with HIV with life-saving antiretroviral treatment (ART) by 2015. In the EAC, Burundi, Kenya, Rwanda and Uganda are on track to meet the 2011 Political Declaration on provision of ART to PLHIV.

Facilities for Provision of ART among Adults

The number of facilities providing ART services has continued to increase. While all hospitals provided ART, a relatively smaller number of the lower level health facilities which are large in number and closer to the rural communities had not been accredited. The process of accreditation for these facilities is ongoing.

Access to ART among Adults

ART has been shown to significantly reduce rates of opportunistic diseases and deaths among people living with HIV and AIDS. There is evidence that provision of and adherence to treatment by the infected individual will also prevent transmission to a negative partner. The increased gap in the

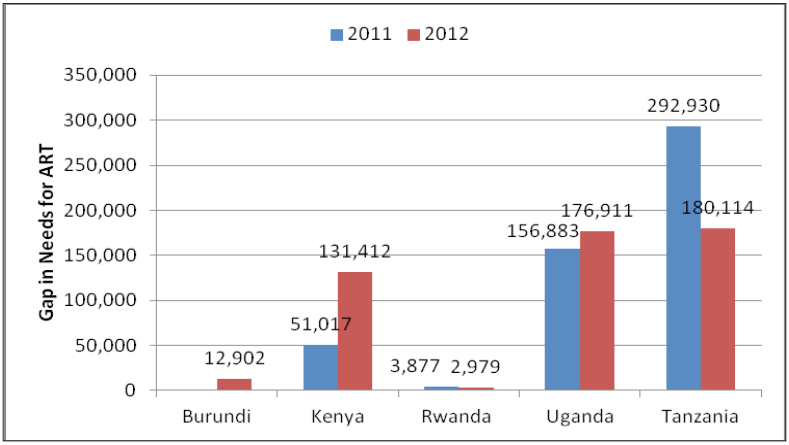
number of people in need of ART in the period between 2011 and 2012 is shown by the table and figure below.

Table: Number of Adults Eligible for ART and on ART, 2011 and 2012

States	2011		2012	
	Adults Eligible	Adults on ART	Adults Eligible	Adults on ART
Burundi			40,000	27,098
Kenya	590,000	538,983	680,000	548,588
Rwanda	100,000	96,123	110,000	107,021
Uganda	470,000	313,117	580,000	403,089
Tanzania	570,000	277,070	580,000	399,886
TOTAL	**1,730,000**	**1,225,293**	**1,990,000**	**1,485,682**

Source: UNAIDS (2013).

Figure: Gap between Number of PLHIV in Need and Accessing ART in 2011 and 2012

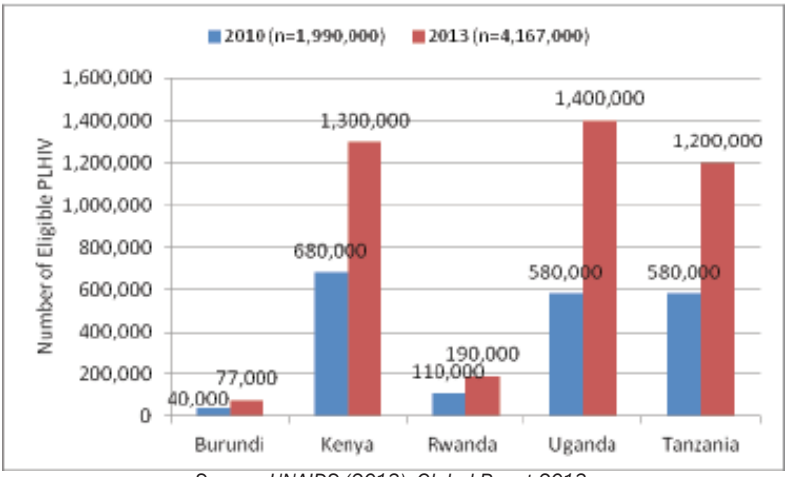


Source: UNAIDS (2013). Global Report 2013

The 2013 WHO guidelines on the use of antiretroviral drugs for treating and preventing HIV infection recommend a CD4 threshold of 500 for initiation of HIV treatment. As such, it is projected that in East Africa, the number of PLHIV that are eligible for ART will double in Burundi, Kenya and Rwanda but more than double in Uganda and Tanzania. The total number of such people will increase from about 2 million to over 4 million.

This significant change in the number of people that become eligible for ART has huge financial and human resource implications in the national response. The figure below shows the expected increase in number of PLHIV eligible for ART as per the WHO 2013 guidelines.

Number of PLHIV Eligible to ART according to Guidelines of 2010 and 2013



Source: UNAIDS (2013). Global Repot 2013.

Access to Antiretroviral Treatment among Infants

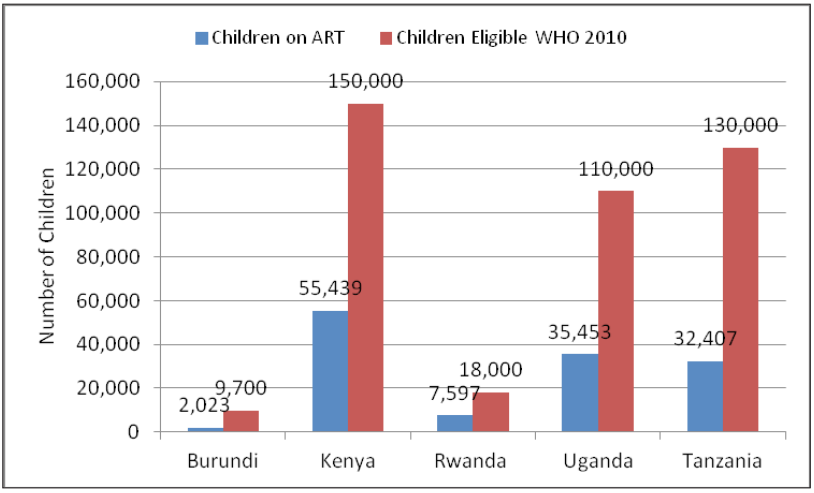
One of the key aspects in elimination of MTCT is that of enhancing availability, access and uptake of ANC services to women. The number of ANC facilities offering PMTCT services needs to be increased to allow greater access by women. By 2010, the coverage was quite good in Kenya (92%), Tanzania (90%) and Uganda (80%) but low in Burundi (35%). In the absence of treatment, fifty percent of HIV-infected infants born to HIV-infected mothers may die before their second birthday.

Access to ART among Children

There was an estimated total of 417,700 children in need of ART in the EAC in 2012. Kenya and Tanzania each contributed more than a third of these children. Coverage has more than doubled between 2009 and 2012 for Kenya (from 18% to 38%), Uganda (17% to 33%) and Tanzania (10% to

26%) but increased modestly from 17% to 21% for Burundi. Overall, however, only 32% (132,919) of the estimated eligible children were on ART. This indicates that access to pediatric ART in East Africa is unacceptably lower compared to that for adults whose coverage is at 75%.

Access and Eligibility to ART by Children in 2012



Source: UNAIDS (2013). Global Report 201

PREVENTING TB DEATHS AMONG PLHIV

Tuberculosis has become a leading cause of death among people living with HIV. Individual Partner State reviews indicate that Rwanda and Kenya are on track to meet the UN's 2011 Political Declaration on reducing deaths due to TB by a half among PLHIV.

TB Situation in East Africa

TB Disease Burden Situation

Kenya, Uganda and Tanzania are among the 22 high-burden countries accounting for approximately 80% of all new TB cases arising globally each year. According to the 2012 WHO report, estimates of the burden of dis-

ease caused by TB in the EAC in 2012 are as follows: (a) incident cases range from 78,000 to 120,000 (b) prevalent cases are from 82,000 to 120,000 people and (c) deaths due to TB range from 5,000 to nearly 10,000. Most cases were in Kenya. The HIV-positive incident TB cases were less than 50% as is shown in the table below.

Estimated Burden of Disease Caused by TB, 2011 (Number in Thousands)

	Population	Mortality	Prevalence	Incidence	HIV-Positive Incident TB Cases
Kenya	41,610	9.2	120	120	47
Uganda	34,509	5	63	67	35
Tanzania	46,218	6.4	82	78	30

Source: WHO (2012). Global Tuberculosis Report 2012.

Co-infection of HIV/TB and Collaborative TB/HIV activities

The performance on the majority of TB/HIV collaborative activities in the region has improved as demonstrated by the increased HIV testing among TB patients and increased screening for TB among patients in HIV care.

Access to ART by People Living with both HIV and TB in East Africa

	51-75%	76-100%
25-50%	• Kenya	• Rwanda
• Uganda		
• Tanzania		

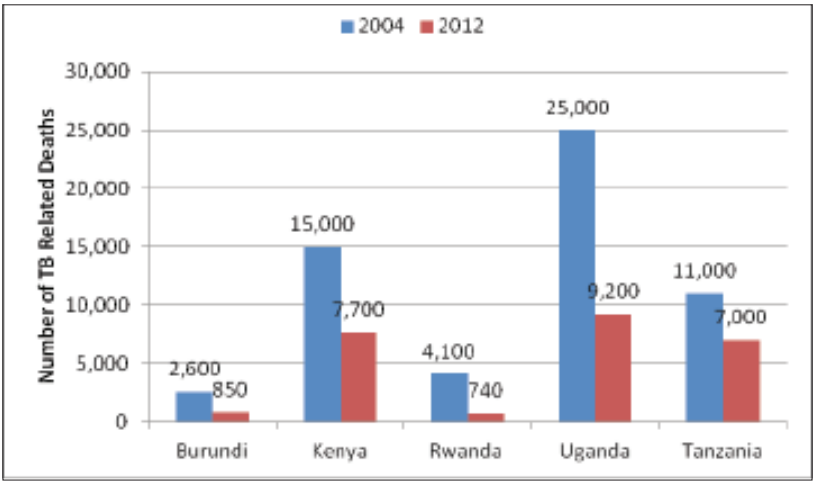
Source: UNAIDS (2013)

TB-related Deaths in the EAC

There has been considerable progress in efforts to reduce the number of TB-related deaths among people living with HIV by 50% by 2015. The estimated number of TB-related deaths among people living with HIV in the East African Community has shown a significant decrease between

2004 and 2012 as indicated in the figure below. This is attributed to the improved TB/HIV programming at both Partner State and regional level.

Number of TB-related Deaths among People Living with HIV in East Africa, 2004 and 2012



Source: UNAIDS (2013). Global Report 2013

GENDER AND HIV RESPONSE

Reducing gender inequality and gender-based violence is not only a pre-requisite for accelerating sustainable human and economic development, but is also perceived as a significant pathway to effectively respond to the HIV and AIDS epidemic. In the EAC Partner States, there is a gender disparity in the prevalence of HIV infection, with women being more affected than men.

Prevalence among women ranges from 2.4% to 8.3% compared to a range of 1.9% to 6.1% among men in the Partner States where the epidemic is generalized; in Zanzibar, where the epidemic is concentrated, 1.1% of women have HIV compared to 0.9% of men. (See table)

Prevalence of HIV among Women and Men in EAC Partner States

Partner State	Source	Women	Men
Burundi	BDHS-2010	2.4	1.9
Kenya	KAIS-2011	6.9	4.4
Rwanda	RDHS-2010	3.7	2.2
Uganda	UAIS-2011	8.3	6.1
Tanzania	THMIS-2011	6.2	3.8
Zanzibar	THMIS-2011	1.1	0.9

FACTORS THAT PREDISPOSE PEOPLE TO HIV INFECTION ACCORDING TO GENDER

Social Factors

There are many harmful socio-cultural practices such as gender inequality and gender-based violence, stigma and discrimination of PLHIV, women and girls, multiple concurrent partnership, polygamy, widow inheritance, early sexual debut etc, that increase the level of vulnerability of women to HIV infection.

Economic Factors

Poverty limits access to services and also increases the likelihood that poor people will engage in early sex and depend on commercial, trans-actional and cross-generational sexual relationships. On the other hand, many affected people have their economic status lowered because of decreased income and increased demands. In East Africa, families and households taking care of orphans are overwhelmed with needs of the OVC that they support.

HIV prevalence in the EAC is, however, positively correlated with wealth. The people in the lowest quintile have less infection while those in the highest quartile have the highest prevalence.

HIV Prevalence in Partner States by Wealth Quintile in EAC Partner States

Wealth Quintile	East African Partner State				
	Burundi	Kenya	Rwanda	Uganda	Tanzania
Lowest	1.2	4.6	2.7	6.3	4.0
Middle	1.2	5.6	2.1	6.9	5.0
Highest	2.7	7.2	5.1	8.2	6.6

Source: BDHS (2010), KDHS 2008-09, RDHS (2010), UAIS (2011), THMIS (2011)

Legal Factors

Some legal frameworks in East Africa are likely to impede behavior change, disclosure and access to HIV-related services. Similarly, throughout East Africa, criminalization of sex work renders women engaged in it vulnerable to SGBV, exploitation, and leaves them no choice but to operate underground while also weakening their negotiating power for protected sex.

ACCESS TO HIV SERVICES AND GENDER

HIV Counseling and Testing (HCT)

Women tend to have greater access to HCT compared to men. In all the Partner States more women than men go for HIV testing. This is partly because counseling and testing for HIV are also offered at ante-natal clinics which are predominantly attended by pregnant women. Among youth aged 15-24 years, girls are more likely to take tests for HIV and get results than boys. This gives women greater opportunity to enjoy the benefits of knowing one's HIV status.

Health Insurance

Medical insurance provides ready access to care and treatment for those enrolled on the health insurance scheme. Based on the findings from the demographic and health surveys, women in the EAC tend to be less covered by health insurance than men. It is only in Rwanda where the opposite is true as is shown in the table below.

Coverage (%) of Health Insurance in the EAC

Partner State	Source	Gender	
		Women	Men
Burundi	BDHS-2010	10	11
Kenya	KDHS-2009	13	23
Rwanda	RDHS-2010	71	66
Uganda	UDHS-2011	1	2
Tanzania	TDHS-2010	6	6

Stigma and Discrimination

Stigma, discrimination, and violation of human rights of people living with HIV are among the major factors that drive the HIV and AIDS epidemic in the region. Nevertheless people in East Africa are more accepting of PLHIV with more than three quarters of East Africans willing to care and support AIDS patients, buy groceries from those that are infected, and allow their children to be taught by teachers with AIDS in 2012.

Stigma and Discrimination Experienced by PLHIV

PLHIV in the EAC experience various forms of stigma and discrimination. These include social stigma and discrimination, internalized stigma, physical and verbal violence and institutional stigma and discrimination.

Social stigma and discrimination presented in the form of PLHIV being excluded from family events, or families being hesitant about spending money on medical and nonmedical needs of PLHIV, for example.

Internalized stigma (also called self-stigma) occurs when people living with HIV view themselves as guilty or responsible for their situation. Many PLHIV feel ashamed of being infected with HIV while others feel suicidal owing to their HIV positive status.

Institutional stigma manifests in settings such as the workplace, schools and health facilities. Workplace related stigma and discrimination include: work colleagues displaying negative attitudes towards PLHIV; PLHIV being sent away/terminated from work, or; being denied opportunities for career growth.

Legal Redress to Stigma and Discrimination

Only half of PLHIV in the region have heard of the Declaration of Commitment on HIV and AIDS which protects the rights of people living with HIV. In addition, less than half are aware of national laws which protect their rights.

Strategic Plans, Stigma and Discrimination

The EAC Partner States have committed to protect the rights of people living with HIV, as well as the rights of women, children, and members of vulnerable and key populations in the context of HIV. Accordingly, the Partner States have integrated stigma and discrimination in their national strategic plans for responding to the HIV and AIDS epidemic. Partner States have put in place legal frameworks to facilitate access to legal aid services by PLHIV, OVC and families infected/affected by AIDS in the community.

SUPPORT FOR FAMILIES AND CHILDREN AFFECTED BY HIV AND AIDS

The number of orphans and vulnerable children in the region is decreasing but is still very high. It rose tremendously throughout the 1990s and early 2000s from a low estimation of 216,000 in 1990 to 3.8 million in 2005. From 2005 when there was a massive scaling up of ART provision, the number of deaths among adults in the region declined and in 2012, there were only an estimated 3.4 million orphans in the region.

The Partner States have incorporated in their respective national strategic plans (NSPs) issues concerning orphans and vulnerable children as well as HIV and AIDS infected and affected groups. Among the issues covered include: economic opportunities and social protection schemes for people infected/affected by HIV (including child-headed households); stigma and discrimination of PLHIV and OVC in the community; increased comprehensive quality psychosocial services, and; provision of livelihood skills and opportunity to cope with socio-economic demands as well as prevention and protection against sexual violence.

FINANCING THE HIV AND AIDS RESPONSE IN THE REGION

Total budgets and actual funding for HIV and AIDS response in the region have continued to increase, signifying greater political commitment of the Partner States in the fight against the epidemic. However, a considerable gap remains between the projected costs of the response and the actual resources mobilized.

Projected Cost Estimates (US $) for Implementation of Partner State National Strategic Plans for HIV and AIDS 2009-2013

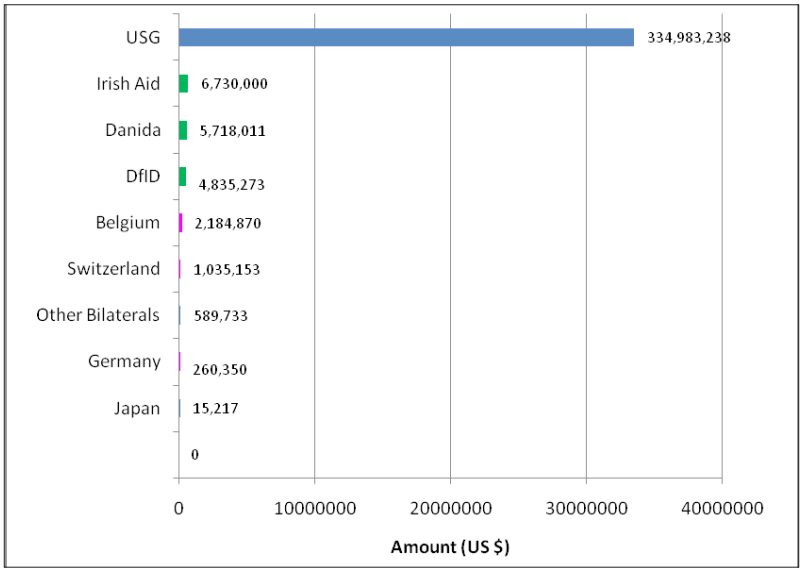
Partner State	2009/10	2010/11	2011/12	2012/13	TOTAL
PROJECTED COST OF NATIONAL STRATEGIC PLAN					
Burundi	28	24	30	61	143
Kenya	671	833	998	1,054	3,556
Rwanda	206	221	243	263	934
Uganda	347	402	585	765	2,099
Tanzania					
FUNDING GAP					
Burundi					
Kenya	261	350	487	569	1,667
Rwanda	70.5	95.4	118.4	140.5	424.8
Uganda	13	13.4	194.7	345	566
Tanzania					

Source: CNLS Burundi (2012), NACC (2009), UAC (2007), CNLS Rwanda (2009).

While governments in the region have integrated HIV and AIDS in their budgetary processes, their domestic investments in HIV and AIDS have remained lower than the contribution from development partners. This means that even if the Partner States increase their domestic expenditures on HIV and AIDS, these are likely to be insufficient in the short and medium term.

Bilateral support: Bilateral donor support is more than three times higher compared to the combined resources contributed by multilateral donors and other international funders.

Funding from external donors for HIV and AIDS in Rwanda, Uganda and Burundi, 2009/10



Source: Rwanda (2012, Mukobe & Kavuma (2011) and Burundi (2010).

Multi-lateral support: The major multi-lateral funding agencies for the HIV epidemic in the region include Global Fund for Fighting AIDS, Tuberculosis and Malaria (GFATM), World Bank, European Commission and UN agencies. GFATM however is the dominant multi-lateral agency, contributing more than 80% of the resources from multi-lateral agencies. (See table)

Sources of Multi-lateral Funding for HIV and AIDS in East Africa, 2009/10

SOURCE	Burundi	Uganda	Rwanda	TOTAL	Percent-age
GFATM	4,372,055	24,170,000	67,389,878	95,931,933	80.4
World Bank	8,605,470			8,605,470	7.2
UN Agencies	1,073,452	10,000,000	1,917,394	12,990,846	10.9
European Commission			1,148,033	1,148,033	1.0
Others			675,167	675,167	0.6
TOTAL	**14,050,977**	**34,170,000**	**71,130,472**	**119,351,449**	**100.0**

Source: Rwanda (2012) and Mukobe & Kavuma (2011) & Burundi (2010).

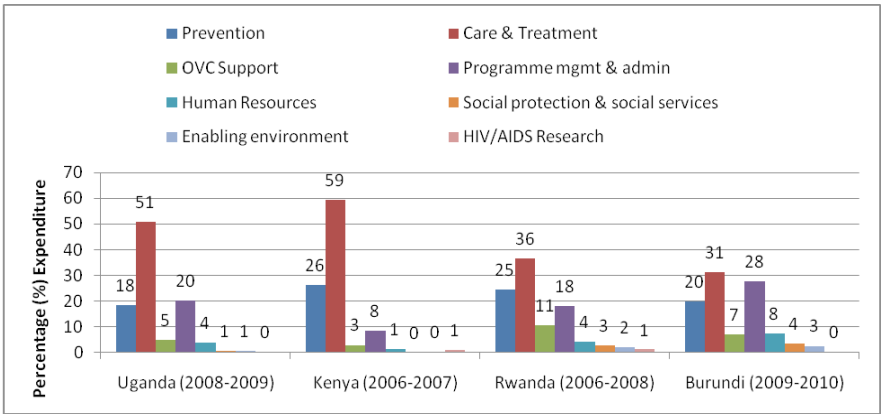
In addition, there is variation in the budgetary allocations of resources for the different key sub-components of the strategic plans in the EAC Partner States. In terms of actual resource utilization, care and treatment took more resources compared to other group categories.

Percentage Resource Allocation in NSP for HIV and AIDS in EAC Partner States

Source: CNLS Burundi (2012), NACC (2009), UAC (2007), CNLS Rwanda (2009).

The National AIDS Spending Assessment focuses on nine categories of expenditure areas, namely: Prevention, care and treatment; OVC support; programme management and support; Human resource, social protection and social services; Enabling environment and HIV and AIDS research.

Breakdown of AIDS Spending by Category for Uganada, Kenya, Rwanda and Burundi, 2006 - 2010



Source: NASA Uganda (20009), Kenya (20007), Rwanda (2008), Burundi (2009-2010)

It is clear that in the four countries, more than half of the resources were spent on care and treatment, while a quarter of the funds were used for prevention. Also noted is the fact that expenditure for program management is relatively high. It is envisaged that with the WHO Guidelines of 2013 for access to ART, this gap is going to increase even further.

One key area that needs addressing using existing resources is for countries to improve resource allocation and utilization in effective interventions. A substantial proportion of resources are expended in programme management and less on prevention. An appropriate balance needs to be made in resource allocation across the different components of the national response.

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